INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Physician Attachment (PA/PA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER'S NAME
Enter the name of the provider who would perform/provide the requested service/procedure.

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ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the provider who would perform/provide the requested service/procedure.

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the referring/prescribing physician in this element.

* *

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D.

2. Read the Prior Authorization Statement before dating and signing the request.

3. Date and sign the attachment.